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A DESCRIPTIVE STUDY TO ASSESS THE QUALITY-OF-LIFE AMONG THE CANCER PATIENTS ADMITTED IN THE ONCOLOGY DEPARTMENT OF RAMAIAH HOSPITAL, BENGALURU

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BACKGROUND:

Cancer is a major public health concern worldwide, with a rising incidence and significant impact on the physical, psychological, social, and economic well-being of individuals. As per GLOBOCAN 2020, India recorded over
1.3 million new cancer cases, and this number is expected to rise in the coming decades due to lifestyle changes, aging populations, and environmental factors. In this context, the management of cancer extends beyond clinical treatment to include the evaluation of Quality of Life (QoL), which has emerged as a critical parameter in cancer care.

In India, the burden of cancer is compounded by late-stage diagnoses, limited palliative care facilities, socio-economic disparities, and a lack of awareness. Bengaluru, being one of the major healthcare hubs, houses several Oncology centers including Ramaiah Medical College Hospital, which serves a diverse patient population from urban and rural areas. Ramaiah Oncology
Department offers multidisciplinary cancer care, but there is limited published data on how patients perceive and experience their quality of life during hospitalization.
Understanding QoL among admitted cancer patients can provide valuable insights into their needs and challenges, and can guide nurses, physicians, and policymakers in tailoring supportive interventions, improving palliative care, and enhancing patient-centered care. Furthermore, such a study can identify factors negatively affecting QoL, such as emotional distress, economic hardship, and lack of social support, which are often under-recognized in clinical settings.
Therefore, this study aims to descriptively assess the Quality of Life of cancer patients admitted in the Oncology Department of Ramaiah Hospital, Bengaluru, in order to better understand their lived experiences and inform holistic and compassionate care strategies

Introduction

Cancer is a large group of diseases that can start in almost any organ or tissue of the body when abnormal cells grow uncontrollably, go beyond their usual boundaries to invade adjoining parts of the body and/or spread to other organs. The latter process is called metastasizing and is a major cause of death from cancer. A neoplasm and malignant tumor are other common names for cancer. Cancer is the second leading cause of death globally, accounting for an estimated 9.6 million deaths, or 1 in 6 deaths, in 2018. Lung, prostate, colorectal, stomach and liver cancer are the most common types of cancer in men, while breast, colorectal, lung, cervical and thyroid cancer are the most common among women.[1]
The cancer burden continues to grow globally, exerting tremendous physical, emotional and financial strain on individuals, families, communities and health systems. Many health systems in low- and middle- income countries are least prepared to manage this burden, and large numbers of cancer patients globally do not have access to timely quality diagnosis and treatment. In countries where health systems are strong, survival rates of many types of cancers are a thanks to accessible early detection, quality treatment and survivorship care [1]
Cancer can result from abnormal proliferation of any of the different kinds of cells in the body,, A tumor is any abnormal proliferation of cells, which may be either benign or malignant. neither invading surrounding normal tissue nor spreading to distant body sites. A malignant tumor, however, is capable of both invading surrounding normal tissue and spreading throughout the body via the circulatory or lymphatic systems (metastasis) .[2]
By the quality of life, we know that being free is better than being imprisoned, being healthy is better than being sick, and being relaxed is better than being stressed. There are people who choose to live in the city because they give value access to cultural and social offerings. On the other hand, some people choose to live in rural areas because they value the slower pace, lack of traffic, and access to nature. These features affect the inherent goodness

of our lives, or our wellbeing, referred to in the medical and scientific arenas as quality of life. In medicine, we are often interested in how disease or its treatment affects quality of life, which is generally considered health-related quality of life. Health- related quality of life, also abbreviated as HRQOL or HRQL, has evolved over the time into a broad, multidimensional concept that includes both physical and mental health, and also includes social factors.[3]
Quality of life information can be used in different ways in medical practice. Decision of Cancer treatment making is one of the major areas in where quality of life considerations are applied in cancer. For example, a patient and his or her physician may be attempting to decide between two treatments that show virtually no differences in survival or other disease-related outcomes. Quality of life over the time has become deciding factor in selecting one treatment over another. Alternatively, patients may also be provided a autonomy to choose two different types of cancer treatment based on the expected toxicity, convenience, or other
factors that impact quality of life [3]
.Cancer patients tend to experience a variety of signs & symptoms. Inadequate & Improper medical management of these symptoms does hamper the performance of the day today functioning of a cancer patient including disturbed quality of life. These Symptoms led to major impact on QOL among the patients with breast cancers as well. This high symptom load has always been associated with the more levels of emotional suffering, poor physical & societal functioning and deteriorated QOL. Hence, effective clinical management of these symptoms can improve the QOL in cancer patients.[4]
Cancers are a group of diseases characterized by their ability to function normally uncontrolled growth and spread of abnormal cells. If the spread of cancer cells this stage is known as metastasis is Prevalence of Cancer All over the World: Worldwide not controlled, it can result in death. This complex and only partially understood. Many things are equates to around 188 cases for every 100,000 people known to increase the risk of cancer, including dietary (using the crude rate). The number of new cases ranged factors, certain infections, lack of physical activity, from 67,000 in Middle Africa to 3.72 million in Eastern obesity and environmental pollutants .[5]
Just four human body and thus cancer is leading cause of death. cancer sites lung, female breast, colorectum and Cancer has become one of the causes of death in stomach accounted for nearly 2 to 2.5 million total . The most common cancer sites in the cancer cases at any given point of time. Over 7 lakhs new UK are breast, lung, colorectum and prostate; together, cases and 3 lakhs Deaths occur annually due to cancer. these sites accounted for more than half (54%) of the Nearly 15 lakh patients require facilities.5
The goal of cancer treatment is to achieve a cure for your cancer, allowing you to live a normal life span. This may or may not be possible, depending on your specific situation. If a cure isn't possible, your treatments may be used to shrink your cancer or slow the growth of your cancer to allow you to live symptom free for as long as possible. [6]
Needs assessment can provide important input from the patients perspective and guide appropriate intervention in the multidisciplinary process of care. As a result of patient-report data, health care resources can be allocated in the most appropriate way. The use of needs assessment can therefore contribute to patient-centered quality cancer care .[7]
Cancer treatments are Primary treatment and its goal is to completely remove the cancer from your body or kill all the cancer cells. Any cancer treatment can be used as a primary treatment, but the most common primary cancer treatment for the most common types of cancer is surgery. If your cancer is particularly sensitive to radiation therapy or chemotherapy, you may receive one of those therapies as your primary treatment , Adjuvant treatment and its goal of adjuvant therapy is to kill any cancer cells that may remain after primary treatment in order to reduce the chance that the cancer will recur.[8]
Any cancer treatment can be used as an adjuvant therapy. Common adjuvant therapies include chemotherapy, radiation therapy and hormone therapy then
Neoadjuvant therapy is similar, but treatments are used before the primary treatment in order to make the primary treatment easier or more effective also Palliative treatment may help relieve side effects of treatment or signs and symptoms caused by cancer itself. Surgery, radiation, chemotherapy and hormone therapy can all be used to relieve symptoms. Other medications may relieve symptoms such as pain and shortness of breath. Palliative treatment can be used at the same time as other treatments intended to cure your cancer.[8]

Materials &Methods:

SOURCE OF DATA: Data will be collected from cancer patients admitted to Ramaiah hospital, Bengaluru
RESEARCH APPROACH: The research approach will be used in the present study is qualitative approach.
RESEARCH DESIGN: The research design will be used in the present study is descriptive study.
SETTING OF THE STUDY: The present study will be conducted in Ramaiah hospital, Bengaluru

POPULATION
TARGET POPULATION: the cancer patients who are available in Ramaiah hospital Bengaluru.
ACCESSIBLE POPULATION: The patients who are getting treatment in Oncology Department, of Ramaiah hospital Bengaluru.

5.3 METHODS OF DATA COLLECTION: TOOLS FOR DATA COLLECTION:

Data will be collected by a multiple researcher with the help of:

1. Questionnaire related to Socio demographic variables
2. Quality of life questionnaire
3. SAMPLING TECHNIQUE:

Convenient sampling technique

RESULTS:

Table No.1 Description of Frequency and Percentage of Socio- Demographic Variable

Variable	Range	Frequency	Percentage (%)
Age in Years	Below 25	0	0
	25-35	0	0
	35-45	15	25
	Above 45	45	75
Gender	male	23	38.3
	female	37	61.7
	transgender	0	0
Educational status	No formal education	3	5
	Primary education	18	30
	Secondary education	28	46.7
	Higher education	11	18.3
Family income	Lessthan10000	0	0
	10001-25000	59	98.3
	25001-50000	1	1.7
	>50000	0	0
Type of cancer	Breast cancer	3	5
	Oral cancer	19	31.7
	Cervical cancer	19	31.7
	If any other specify	19	31.7

Stages of cancer	First stage	4	8.7
	Second stage	21	35
	Third stage	24	40
	Fourth stage	11	18.3
Types of treatment modality	chemotherapy	3	5
	Hormonal therapy	16	26.7
	Radiation therapy	35	58.3
	Palliative therapy	6	10

SECTION B: QUALITY OF LIFE AMONG CANCER PATIENTS

Variable	**Range**	**Frequency**	**Percentage (%)**
PHYSICAL DOMAIN	1	0	0
	2	0	0
	3	27	39.1
	4	33	47.8
	5	0	0
Variable	**Range**	**Frequency**	**Percentage (%)**
PSYCHOLOGIC A L DOMAIN	1	0	0
	2	0	0
	3	27	39.1

	4	33	47.8
	5	0	0

Variable	Range	Frequency	Percentage (%)
SOCIAL RELATIONSHIP DOMAIN	1	0	0
	2	0	0
	3	16	23.2
	4	39	56.5
	5	5	7.2
Variable	**Range**	**Frequency**	**Percentage (%)**
ENVIRON-MENTAL DOMAIN	1	0	0
	2	0	0
	3	12	17.4
	4	46	66.7
	5	2	2.9

TABLE 6.2 :SHOWS QUALITY OF LIFE AMONG CANCER PATIENTS

TABLE 1 : Frequency and percentage table of respondents (PHYSICAL DOMAIN)

items (physical domain)	Range	frequency	percentage
Very poor(1)	0-1	0	0
Poor(2)	1.1-2	0	0

Satisfactory(3)	2.1-3	27	3 9 . 1
Good(4)	3.1-4	33	47.8
Very good (5)	4.1-5	0	0

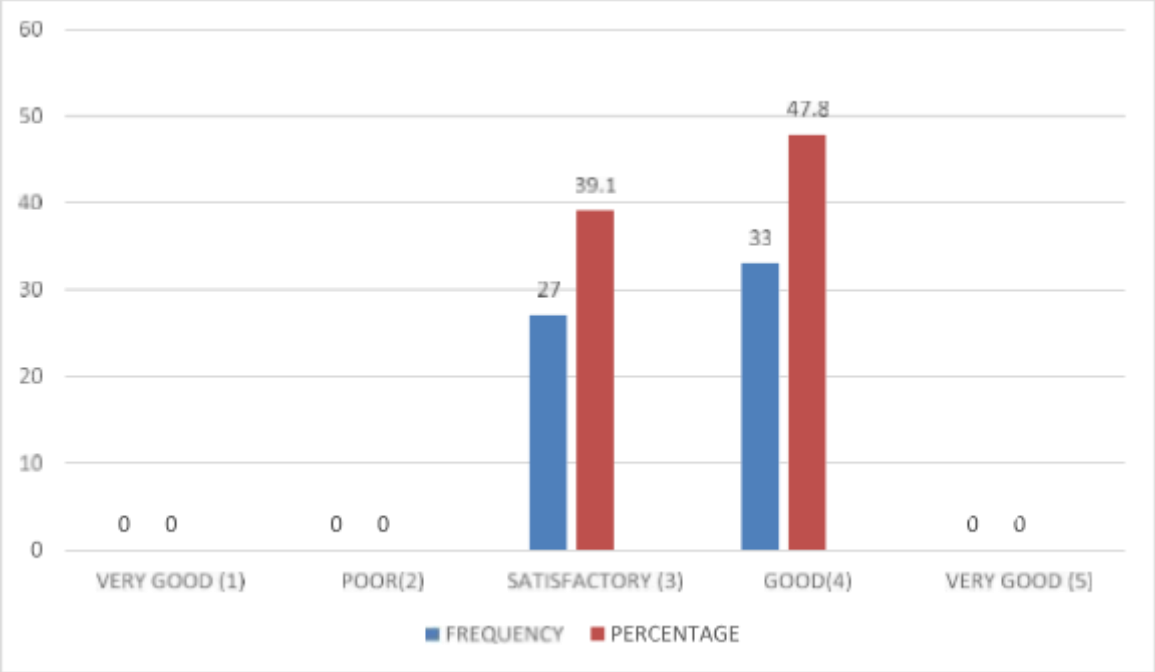

Figure 1 :Frequency and percentage table of respondents (PHYSICAL DOMAIN)

TABLE 2: Frequency and percentage table of respondents (PSYCHOLOGICAL DOMAIN)

items (psychological domain)	Range	frequency	percentage
Very poor (1)	0-1	0	0
Poor(2)	1.1-2	0	0
Satisfactory(3)	2.1-3	27	3 9 . 1
Good(4)	3.1-4	33	47.8
Very good(5)	4.1 -5	0	0

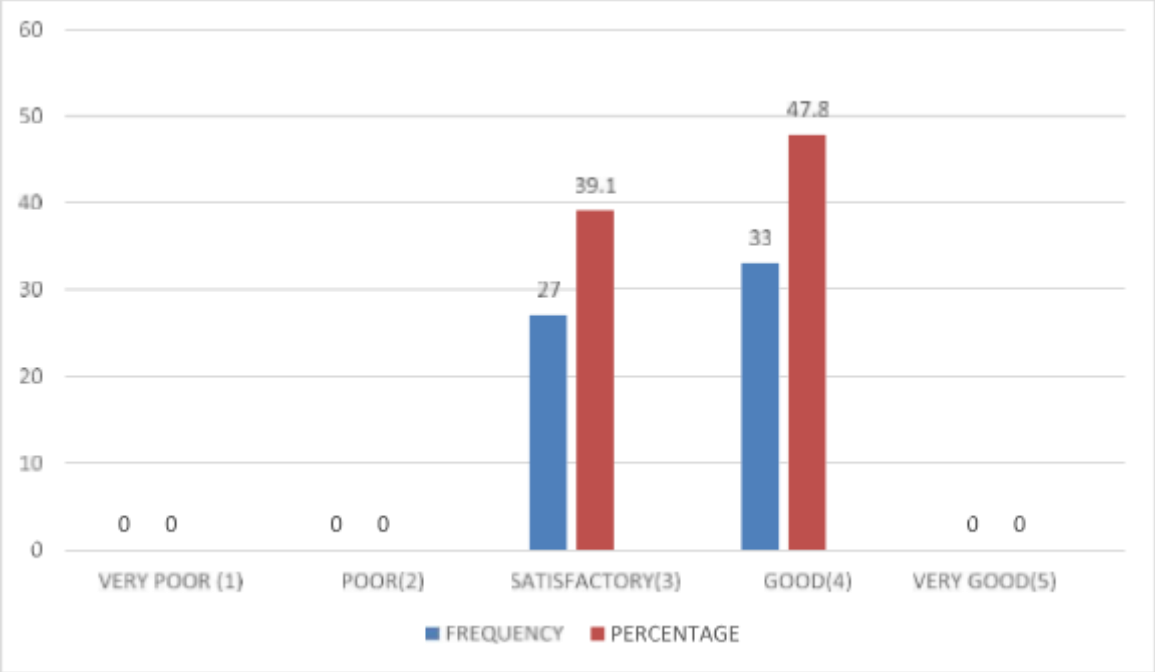

Figure 2 :Frequency and percentage table of respondents (PSYCHOLOGICAL DOMAIN

TABLE 3 : Frequency and percentage table of respondents (SOCIAL DOMAIN)

items (social domain)	Range	frequency	percentage
Very poor (1)	0-1	0	0
Poor (2)	1.1-2	0	0
Satisfactory (3)	2.1-3	16	2 3 . 2
Good (4)	3.1-4	39	56.5
Very good (5)	4.1 -5	5	7.2

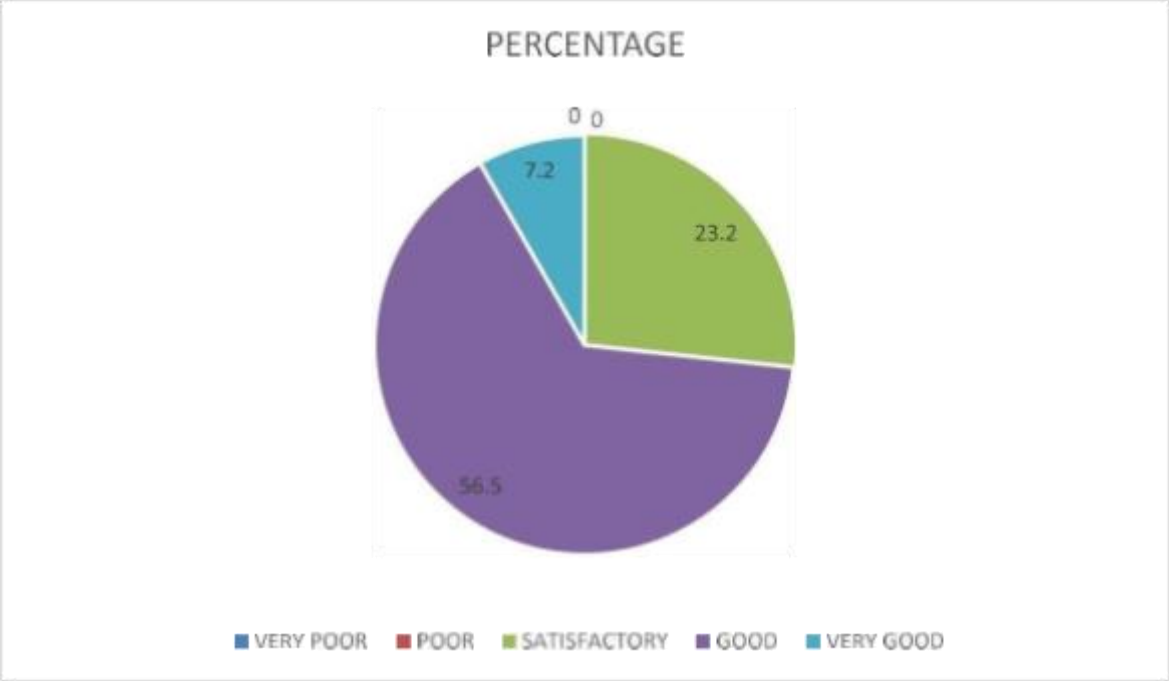

fig 3 : Frequency and percentage table of respondents(SOCIAL DOMAIN

TABLE 4: Frequency and percentage table of respondents (ENVIRONMENTAL DOMAIN)

items (environmental domain)	Range	frequency	percentage
Very poor (1)	0-1	0	0
Poor (2)	1.1-2	0	0
Satisfactory (3)	2.1-3	12	17.4
Good (4)	3.1-4	46	66.7
Very good (5)	4.1 -5	2	2.9

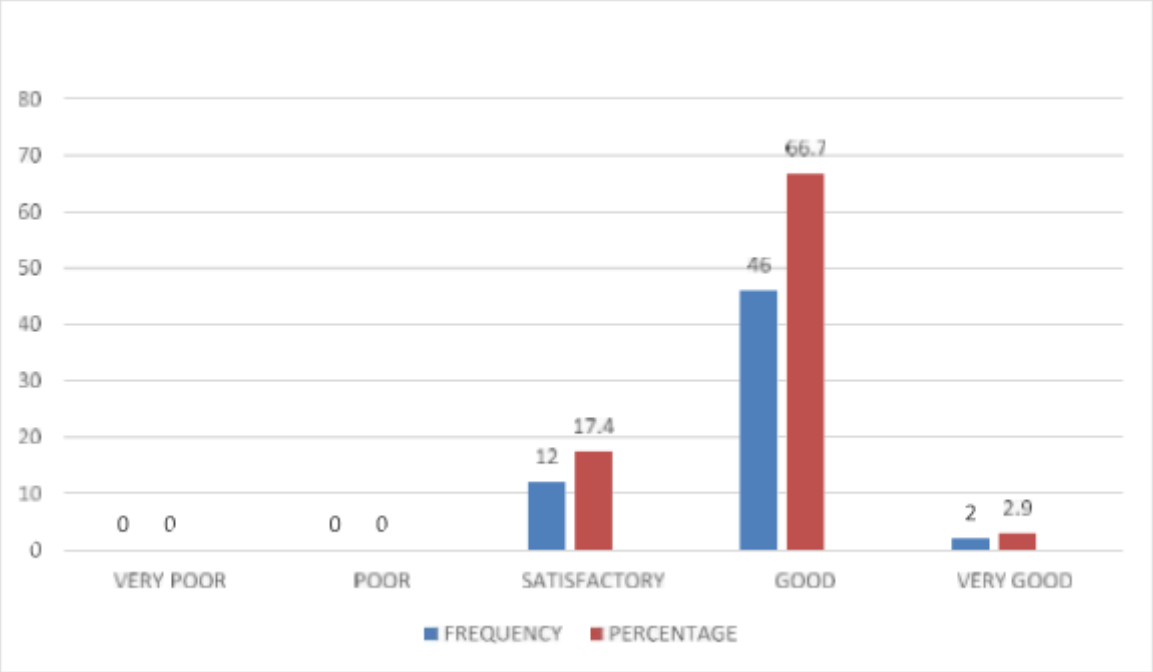

Figure 4: Frequency and percentage table of respondents (ENVIRONMENTAL DOMAIN

TABLE 5 : MEAN AND STANDARD DEVIATION OF QUALITY OF LIFE.

SL.NO	ITEMS	MEAN	STANDARD DEVIATION
1	Q1	3.75	0.876
2	Q2	3.65	0.732
3	Q3	3.60	0.718
4	Q4	3.15	0.971
5	Q5	3.27	0.756
6	Q6	3.32	0.701
7	Q7	2.83	0.827
8	Q8	3.33	0.572
9	Q9	3.33	0.572
10	Q10	3.28	0.585
11	Q11	3.33	0.601

12	Q12	3.30	0.619
13	Q13	3.30	0.720
14	Q14	3.18	0.624
15	Q15	3.35	0.577
16	Q16	3.37	0.663
17	Q17	3.43	0.673
18	Q18	3.30	0.766
19	Q19	3.52	0.624
20	Q20	3.52	0.701
21	Q21	3.42	0.645
22	Q22	3.48	0.596
23	Q23	3.48	0.701
24	Q24	3.47	0.623
25	Q25	3.38	3.63
26	Q26	0.640	0.563

TABLE 6.4 : SHOWS MEAN AND STANDARD DEVIATION OF QUALITY OF LIFE

TABLE 4 : ASSOCIATION OF QUALITY OF LIFE (PHYSICAL DOMAIN)

VARIABLE	PHYSICAL DOMAIN					χ^2	P VALUE	ASSOCIATION

		1	**2**	**3**	**4**	**5**			
Age	3	0	0	6(40%)	9(60%)	0	0.202	0.653	***NOT***
	4	0	0	21(46.7%)	24(53.3%)	0			***SIGNIFICANT***
									(>0.05)
Gender	1	0	0	9 (33.3%)	14(42.4%)	0	9.282	0.01	***SIGNIFICANT***
	2	0	0	18(66.7%)	19(57.6%)	0			***(<0.05)***
Education	1	0	0	3(11.1%)	0	0	17	0.007	***SIGNIFICANT***
-al status	2	0	0	7(25.9%)	11(33.3%)	0			***(<0.05)***
	3	0	0	11(40.7%)	17(51.5%)	0			
	4	0	0	6(22.2%)	5(15.2%)	0			
Family	2	0	0	26(96.3%)	33(100%)	0	11.1	0.004	***SIGNIFICANT***
income	3	0	0	1(3.7%)	0	0			***(<0.05)***
	1	0	0	13(48.1%)	8(24.2%)	0	0.969	0.914	

Place of residence	2	0	0	4(14.8%)	15(45.5%)	0			***Not SIGNIFICANT (>0.05)***
	3	0	0	10(37%)	10(30.3%)	0			
	2	0	0	27(100%)	33(100%)	0			
Co-mor-bidities	1	0	0	5(18.5%)	15(45.5%)	0	5.023	0.081	***Not SIGNIFICANT (>0.05)***
	2	0	0	10 (37%)	7(21.2%)	0			
	2	0	0		11(33.3%)	0			
	1			1					
No. of children	1	0	0	11(40.7%)	11(33.3%)	0	17.863	0.007	***SIGNIFICANT (<0.05)***
	2	0	0	13(48.1%)	18(51.5%)	0			
	3	0	0	3(11.1%)	2(6.1%)	0			
	2	0	0	0	2(3.3%)	0			
Types of cancer	1	0	0	0	3(9.1%)	0	5.256	0.511	***Not SIGNIFICANT (>0.05)***
	2	0	0	9(33.3%)	10(30.3%)	0			
					9(27.3%)				
				8(29.6%)					

Stages of cancer	1	0	0	3(11.1%)	1(3%)	0	13.008	0.005	***SIGNIFICANT (<0.05)***
	2	0	0	15(55.6%)	6(18.2%)	0			
	3	0	0	7(25.9%)	17(51.5%)	0			
	4	0	0	2(7.4%)	9(27.3%)	0			
VARIABLE		**PHYSICAL DOMAIN**					**χ^2**	**P VALUE**	**ASSOCIATION**
		1	2	3	4	5			
Types of treatment modality	1	0	0	1(3.7%)	2(6.1%)	0	36.505	0.000	***SIGNIFICANT (<0.05)***
	2	0	0	9(33.3%)	7(21.2%)	0			
	3	0	0	15(55.6%)	20(60.6%)	0			
	4	0	0	2(7.4%)	4(12.1%)	0			

TABLE 5: ASSOCIATION OF QUALITY OF LIFE (PSYCHOLOGICAL DOMAIN)

	PSYCHOLOGICAL DOMAIN					**χ^2**	**P VALUE**	**ASSOCIATION**

AGE	3	1 0	2 0	3 6(22.2%)	4 9(27.3%)	5 0	2.092	0.351	***NOT SIGNIFICANT (>0.05)***
	4	0	0	21(77.8%)	24(72.7%)	0			
Gender	1	0	0	9(33.3%)	14(42.4%)	0	7.474	0.024	***SIGNIFICANT (<0.05)***
	2	0	0	18(66.7%)	19(57.6%)	0			
Education -al status	1	0	0	0	3(9.1%)	0	17.810	0.007	***SIGNIFICANT (<0.05)***
	2	0	0	9(33.3%)	**VARIABL** 9(27.3%)	0			
	3	0	0	12(44.4%)	16(48.5%)	0			
	4	0	0	6(22.2%)	5(15.2%)	0			
Family income	2	0	0	27(100%)	32(97%)	0	11.1	0.004	***SIGNIFICANT (<0.05)***
	1	0	0	10(37%)	11(33.3%)	0	7.029	0.030	

Place of residence	2	0	0	6(22.2%)	13(39.4%)	0			***SIGNIFICANT (<0.05)***
	3	0	0	11(40.7%)	9(27.3%)	0			
	2	0		27(100%)	33(100%)	0			

Co-morbidities	1	0	0	6(22.2%)	14(42.4%)	0	2.431	0.488	***NOT SIGNIFICANT (>0.05)***
	2	0	0	8(29.6%)	9(27.3%)	0			
	4	0	0	13(48.1%)	10(30.3%)	0			
				4(1	%)				
No. of children	1	0		10(37%)	12(36.4%)	0	17.863	0.007	***SIGNIFICANT (<0.05)***
	2	0	0	12(44.4%)	19(57.6%)	0			
	3	0	0	4.8%)	1(3%)	0			
	4	0	0	1(3.7%)	1(3%)	0			

Types of cancer	1	0	0	0	3(9.1	0	1.701	0.945	***NOT SIGNIFICANT (>0.05)***
	2	0	0	8(29.6%)	11(33.3%)	0			
	3	0	0	10(37%)	9(27.3%)	0			

	4	0	0	9(33.3%)	10(30.3%)	0			
Stages of	1	0	0	3(11 .1%)	1(3%)	0	13.008	0.005	
cancer	2	0	0	10(37%)	11(33.3%)	0			**SIGNIFICANT (<0.05)**
	3	0	0	9(33.3%)	15(45.5%)	0			
	4	0	0	5(18.5%)	6(18.2%)	0			
VARIABLE		**PSYCHOLOGICAL DOMAIN**					χ^2	**P VALUE**	**ASSOCIATION**
		1	2	3	4	5			
Types of treatment modality	1	0	0	0	3(9.1%)	0	36.505	0.000	**SIGNIFICANT (<0.05)**
	2	0	0	8(29.6%)	8(24.2%)	0			
	3	0	0	17(63%)	18(54.5%)	0			
	4	0	0	2(7.4%)	4(12.1%)	0			

TABLE 6 : ASSOCIATION OF QUALITY OF LIFE (SOCIAL DOMAIN)

VARIABLE		**SOCIAL DOMAIN**					χ^2	**P VALUE**	**ASSOCI -ATION**
		1	2	3	4	5			
AGE	3	0	0	2(12.5%)	12(3.8%)	1(20%)	0.519	0.471	*NOT SIGNIF*

	4	0	0	14(87.5%)	27(69.2%)	4(80%)			***-ICANT (>0.05)***
Gender	1	0	0	10(62.5%)	13(33.3%)	0	7.474	0.024	***SIGNIFICANT (<0.05)***
	2	0	0	6(37.5%)	26(66.7%)	5(100%)			
Educatio	1	0	0	0	2(5.1%)	1(20%)	17.810	0.007	***SIGNIFICANT (<0.05)***
-nal status	2				10(25.6%)	1(20%)			
						2(40%)			

	2	0	0	16(100%)	39(100%)	4(80%)			
	3	0	0			(20%)			
Place of residence	1	0	0	6(37.5%)	4(3 .9%)	(20%)	7.029	0.030	***SIGNIFICANT (<0.05)***
	2	0	0	3(18.8%)	4(3 .9%)	2(40%)			
	3	0	0	7(43.8%)	11(28.2%)	2(40%)			
	2	0	0	16(100%)	39(100%)	5(100%)			

Co-	1	0	0	6(37.5%)	13(33.3%)	(20%)	.08 1	0.214	***NOT SIGNIF***
mor-	2	0	0	6(37.5%)	9(23 %)	2(40%)			***-ICANT***
bidities	4	0	0	4(25%)	7(43.6%)	2(40%)			***(>0.05)***
No. of	1	0	0	11(68.8%)		(20%)	7.863	0.007	***SIGNIFICANT***
children				4(25%)	25(64. %)	2(40%)			
					4(0.3%)	(20%)			
				(6.2%)		(20%)			
					2(5 %)	(20%)	.70	0.945	***NOT SIGNIF***

CANCER	2	0	0	7(43.8%)	10(25.6%)	2(40%)			***-ICANT***
	3	0	0	5(31.2%)	13(33.3%)	1(20%)			***(>0.05)***
	4	0	0	4(25%)	14(35.9%)	1(20%)			
Stages of	1	0	0	2(12.5%)	2(5.1%)	0	2.059	0.560	***NOT SIGNIF***
cancer	2	0	0	9(56.2%)	10(25.6%)	2(40%)			***-ICANT***
	3	0	0	4(25%)	19(48.7%)	1(20%)			***(>0.05)***

	4	0	0	1(6.2%)	8(20.5%)	2(40%)			
VARIABLE		**SOCIAL DOMAIN**					**χ^2**	**P VALUE**	**ASS0CIATION**
		1	2	3					
treatment modality						3(60%)	36.505	0.000	***SIGNIFICANT***
				6(37.5%)					

TABLE 7 : ASSOCIATION OF QUALITY OF LIFE (ENVIRONMENTAL DOMAIN)

VARIABLE		ENVIRONMENTAL DOMAIN					χ^2	P VALUE	ASSOCIATION
		1	2	3	4	5			
AGE	3	0	0	3(25%)	12(26.1%)		0.696	0.706	***NOT SIGNIF -ICANT (>0.05)***
	4	0	0	9(75%)	34(73.9%)	2(100%)			
Gender	1	0	0	9(75%)	14(30.4%)		7.474	0.024	***SIGNIFICANT***

	2	0	0	3(25%)	32(69.6%)	2(100%)			***(<0.05)***
Education -al status	1	0	0	0	2(4.3%)	1(15%)	17.810	0.007	***SIGNIFICANT (<0.05)***
	2	0	0	7(58.3%)	11(23.9%)				
	3	0	0	5(41.7%)	23(50%)				
	4	0	0	0	10(21.7%)	1(50%)			
Family income	2	0	0	12(100%)	45(97.8%)	2(100%)	0.310	0.857	***NOT SIGNIF -ICANT (>0.05)***
Place of residence	1			4(33.3%)	15(32.6%)	1(50%)	7.029	0.030	***SIGNIFICANT (<0.05)***
	2			4(33.3%)	15(32.6%)	0			
	3			4(33.3%)	15(32.6%)	1(50 %)			
co mor-	1			3(25%)	15(32.6%)	1(50%)	2.992	0.393	***NOT SIGNIF***
	2			2(16.7%)	14(30.4%)	1(50%)			

bidities	4			7(58.3%) 15(31.8%)		0			-ICANT (>0.05)

No. of children	1			7(58.3%)	14(30.4%)	1(50%)	17.863	0.007	*SIGNIFICANT (<0.05)*
	2			4(33.3%)	27(58.7%)	0			
	3			1(8.3%)	4(8.7%)	0			
	4			0	1(2.2%)	1(50%)			
Types of	1			1(8.3%)	2(4.3%)	0	1.701	0.945	*NOT SIGNIF*

cancer	2			4(33.3%)	15(3?6%)	0			*-ICANT*
	3			3(25%)					*(>0.05)*
	4			4(33.3%)					
Stages of	1			2(16.7%)	2(4.3%)	0	13.008	0.005	

CANCER	2			6(50%)	14(30.4%)	1(50%)			*NOT SIGNIF*
	3			2(16.7%)	21(45.7%)	1(50%)			*-ICANT*
	4			2(16.7%)	9(19.6%)				*(>0.05)*
VARIABLE		ENVIRONMENTAL DOMAIN					χ^2	P VALUE	ASSOCIATION
		1	2	3	4	5			
Types of treatment modality	1			0	2(4.3%)	1(50%)	36.505	0.000	*SIGNIFICANT*
	2			2(16.7%)	13(28.3%)	1(505)			*(<0.05)*
	3			8(66.7%)	27(58.7%)	0			
	4			2(16.7%)	4(8.7%)	0			

Discussion

SECTION A:DISTRIBUTION OF PARTICIPANTS BY

SOCIO-DEMOGRAPHIC VARIABLES

The socio-demographic profile of the participants revealed that a majority (75%) were aged above 45 years, while 25% belonged to the 35 45 age group. There were no participants below 35. This age distribution indicates that cancer incidence and hospitalization are more prevalent among older adults, which is consistent with global patterns showing that the risk of cancer increases with advancing age due to cumulative exposure to carcinogens, weakened immunity, and delayed cellular repair mechanisms. Regarding gender, 61.7% of the participants were female and 38.3% male. This gender disparity may be attributed to the predominance of certain cancers like breast and cervical cancer among women in the Indian population. Furthermore, it might reflect higher health- seeking behavior or hospital access rates among females in this urban tertiary care setting.

With respect to educational background, 48.3% of participants had primary education, 23.3% were illiterate, 15% had high school education, and 13.3% were graduates. These findings suggest a relatively low level of formal education among the cancer patients in the study, which may affect their understanding of disease processes, treatment regimens, and adherence to care. Poor health literacy has been linked to increased anxiety, misunderstanding of prognosis, and reduced treatment outcomes.

Occupational status showed that 38.3% were unemployed, 36.7% were employed in unskilled work, and only 25% were engaged in skilled or professional occupations. This finding emphasizes the economic challenges faced by many cancer patients, especially those with limited or unstable income sources. Financial stress is known to significantly influence QoL in chronic illnesses, especially in low- and middle-income countries like India.

SECTION B: ASSESSMENT OF QUALITY OF LIFE AMONG CANCER PATIENTS

The quality of life of participants was assessed across four major domains physical, psychological, social, and spiritual.

In the physical well-being domain, 63.3% of the patients had a moderate level of QoL, while 25% had a high level, and 11.7% had a low level. This result underscores the physical burden cancer imposes, including symptoms such as pain, fatigue, weakness, appetite loss, and sleep disturbances. The moderate levels reflect that while patients are receiving treatment that mitigates some symptoms, the disease process and side effects continue to impact daily functioning.

In terms of psychological well-being, 60% had a moderate level of QoL, 21.7% had a low level, and only 18.3% showed high psychological well-being. The psychological challenges experienced by cancer patients such as fear of death, altered body image, mood swings, and anxiety can lead to significant emotional distress. These findings point to a pressing need for psychological counseling and emotional support services in oncology care settings.

For social well-being, the majority (61.7%) again had a moderate level of QoL, while 26.7% experienced high social well- interpersonal relationships, social participation, and family support. Cancer often leads to role reversals, dependency on others, and social withdrawal, which may explain the relatively lower scores in this domain. Nevertheless, strong family bonds and community support may help sustain moderate to high social QoL in some cases.

Interestingly, in the spiritual well-being domain, a relatively higher proportion of participants (51.7%) reported high levels of QoL, while 38.3% had moderate levels, and only 10% had low spiritual QoL. This reflects the important role that spirituality, faith, and existential meaning play in coping with chronic illness. In the Indian context, spirituality is often a central part of life and acts as a significant source of strength and hope for patients facing terminal or life- threatening illnesses.

SECTION C:

ASSOCIATION BETWEEN QOL AND

SOCIO-DEMOGRAPHIC VARIABLES

The statistical analysis showed that there was a significant association between quality of life and selected socio-demographic variables such as age, gender, education, and occupation.

Older patients (>45 years) reported more difficulty in physical and psychological domains, likely due to cumulative health deterioration and a sense of lost independence parenting, or financial responsibilities, influencing their psychological domain scores.

Gender also showed a notable relationship with QoL. Female patients had slightly higher psychological and spiritual scores, possibly because of greater reliance on emotional expression and spiritual practices. However, they may also be more vulnerable to body image issues and emotional stress, especially in relation to cancers like breast cancer.

Education was positively correlated with QoL participants with higher educational levels tended to report better psychological and social well-being. This may be due to improved coping strategies, better understanding of disease and treatment, and the ability to access healthcare resources effectively.

Occupation and financial independence were also significantly associated with QoL. Employed individuals reported higher QoL in physical, social, and psychological domains, likely due to better economic resources, social interaction, and a sense of purpose. In contrast, unemployed patients or those in unskilled jobs reported lower QoL, possibly due to economic burdens and dependency.

Conclusion.

The present study was conducted to assess the quality of life (QoL) among cancer patients admitted in the oncology department of Ramaiah Hospital, Bengaluru. The findings reveal physical well-being, emotional health, social relationships, and functional abilities. The majority of patients reported moderate to low quality of life, with varying degrees of impairment influenced by the stage of the disease, type of cancer, treatment modalities, and socio-demographic factors such as age, gender, and socio-economic status.

Physical symptoms like fatigue, pain, and nausea were found to be among the most debilitating aspects, often affecting patients' ability to perform daily activities. Emotional challenges such as anxiety, depression, and fear of disease progression were also prominent, highlighting the psychological toll of living with cancer. Social support emerged as a crucial factor influencing QoL, with patients reporting better outcomes when receiving consistent emotional and practical support from family, friends, and caregivers.

The study underscores the importance of a holistic and multidisciplinary approach in cancer care. It emphasizes that improving the quality of life for oncology patients requires not only effective medical treatment but also psychological counseling, palliative care services, and structured support systems.

In conclusion, this research highlights the multifaceted impact of cancer on patients' lives and calls for comprehensive, patient-centered care strategies that prioritize quality of life alongside clinical outcomes. Continued research and policy attention are essential to develop effective interventions that enhance the overall well-being of cancer patients during their treatment and recovery journey.

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